Adverse Incident Reporting Form

This form **must** be faxed/emailed to the appropriate health plan of the member addressed below **within 24 hours** of the incident occurrence.

Please fax/email to

Aetna: 1-860-262-9174 **Amerigroup: 1-855-859-5044** **ACLA: 1-844-341-7641** **LHCC 1-877-401-8173**

UHC: mike.teague@uhc.com

Member Name:	**Diagnosis:**
Member Number:	**Provider Level of care:**
Member Date of Birth:	**Incident Location:**
Gender :	**Date and Time of Incident:**
Legal Status:	**Date Form Completed:**

Check any of the following categories that were involved:

☐	Death	☐	Abuse	☐	Seclusion
☐	Attempted Suicide	☐	Neglect	☐	Restraint (Physical/Mechanical, Chemical)
☐	Significant Medication Error	☐	Exploitation	☐	Other (please explain)
☐	Need for Emergency Services	☐	Extortion		
☐	Elopement	☐	Injury/illness (Beyond First Aid)		

Description of Event: (including specifics on incident, using as many pages as necessary, numbering, dating, & signing each)

Action taken to ensure safety of all involved: (including debriefing efforts and steps to avoid similar future events)

☐ Yes ☐ No	Parent/Guardian notified?	Date/Person notified:
☐ Yes ☐ No	Law enforcement/Protective services notified(if applicable)?	If yes, agency and contact information:
☐ Yes ☐ No	Member seen by psychiatrist, physician or nurse after incident?	If yes, treatment:

Signature: _____ **Date:** _____

Print Name: _____

Provider: _____

Email/Phone No.: _____

Version: January 2016